

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 32211

Registration District No. 10

Primary Registration District No. 305-8

Registrar's No. 165

## 1. PLACE OF DEATH:

(a) County ST CHARLES  
(b) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: ST JOSEPH'S HOSPITAL  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 WEEK  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT  
FULL NAMEJACKSON WITHROW3. (b) If veteran,  
name war \_\_\_\_\_3. (c) Social Security  
No. \_\_\_\_\_

4. Sex MALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced SINGLE  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased UNKNOWN  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
Approx. 80 hr. min.

9. Birthplace LINCOLN Co. MO.  
(City, town, or county) (State or foreign country)10. Usual occupation RETIRED11. Industry or business LABORER (GENERAL)12. Name SAMUEL WITHROW13. Birthplace UNKNOWN PENNA.  
(City, town, or county) (State or foreign country)14. Maiden name ELIZABETH WRIGHT15. Birthplace UNKNOWN VIRGINIA  
(City, town, or county) (State or foreign country)16. (a) Informant COUNTY COURT RECORD(b) Address LINCOLN Co.17. (a) BURIAL (b) Date thereof 9/22/43  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation FAVY CEMETERY18. (a) Signature of funeral director Wompa Burial Home(b) Address Law. Mo.19. (a) 9/22/43 (b) Emmet E. Paul  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County LINCOLN  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. COUNTY FARM  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month SEPT. day 21  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.21. I hereby certify that I attended the deceased from Sept 18  
1943 to Sept 21 1943  
that I last saw him alive on Sept 21 1943  
and that death occurred on the date and hour stated above.Immediate cause of death Uræmia Duration \_\_\_\_\_Due to Prostatic tumor ?

Due to \_\_\_\_\_

Other conditions Shrapnelated inguinal hernia  
(Include pregnancy within 3 months of death)Major findings: Shrapnelated left inguinal hernia  
Of operations \_\_\_\_\_  
Of autopsy 0

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature B. L. Neubauer (M. D. or other) MD  
Address St. Charles Date signed 9/22/43

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*Joseph J. Marsh*

Licensed Embalmer No. *3932*

P. O. Address *Troy, Mo.*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Oct.

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
(a) County St. Charles  
(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Jackson Withrow  
3. (b) If veteran \_\_\_\_\_ 3. (c) Social Security  
name war \_\_\_\_\_ No. \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife If  
alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.  
alt. 80

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo. (b) County Lincoln  
(c) City or town Co. Farm (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept. year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_,  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_,  
and that death occurred on the date and hour stated above.  
Immediate cause of death Uremia Duration \_\_\_\_\_  
Prostatic tumor  
Due to Benign hypertrophy  
Due to Strangulated Inguinal Hernia  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings: Same 137a  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTAL

MOTHER FATHER

PHYSICIAN  
Underline the cause to which death should be charged statistically.

32411